NavMed 369 RESTRICTED

NAVY DEPARTMENT

BUMED NEWS LETTER

a digest of timely information

Captain Vincent Hernandez, (MC), USN

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Diagnostic Significance of Lymphadenopathy in Filariasis: The clinical picture of filariasis observed in several hundred marines at Klamath Falls is one of infrequent objective symptoms. At the beginning of a period of observation of 18 months, retrograde lymphangitis, lymphedema and lymphadenitis were

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relatively prevalent, but with the passage of time there has been a gradual decrease in incidence of these findings. At present, these findings are so relatively infrequent that there is real difficulty in establishing the diagnosis of filariasis (Wuchereria bancrofti) in the serviceman. A history of exposure in endemic areas with subsequent appearance of a transient retrograde lymphangitis, localized lymphedema or lymphadenitis is presumptive evidence of infection. Circulating microfilariae are so rarely found that routine examination of thick blood smears for diagnosis is impractical. Various antigens for skin testing, chiefly Dirofilaria immitis, are helpful in diagnosis, but cannot be relied upon in the individual case. Examination of biopsied lymphatic tissue reveals a suggestive architecture and the diagnosis is definite when the adult worm or worm remnants are demonstrable, but biopsy is not a procedure adaptable for wide-scale usage. In a few cases there has been only a history of exposure without objective findings, microfilariae having been detected in thick blood smears quite by chance.

Frequently the palpable lymph node is the only tangible remaining evidence of infection, and there appears to be a tendency to attach undue significance to its presence when it is associated with an existing diagnosis of filariasis. This tendency exists even in medical officers accustomed to observing many cases of filariasis daily. In order to evaluate the importance of palpable lymph nodes in confirmed cases of filariasis, a careful examination of their presence, size and number was made in three different groups of men by medical officers familiar with the disease. The three groups were established as follows:

(a) 200 cases of filariasis with history of symptoms characteristic of the disease.

(b) 271 cases of malaria in patients who had served in the same general tropical areas as the men in group (a).

(c) 98 men of comparable age group who had never been overseas.

The medical officers were not permitted to know the diagnosis of the subject being examined and they were asked to record the findings and to diagnose each case on the basis of physical examination alone.

The results may be briefly summarized as follows:

1. The diagnosis of filariasis could not be made in more instances than could be accounted for by pure chance, even by doctors familiar with all stages of the infection.

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2. The percentage of men with demonstrable adenopathy was as follows:

Group (a) - Filariasis	60%
Group (b) - Malaria	57%
Group (c) - Controls	55%

The differences are considered not to be significant.

3. It was also observed that the average number of nodes in any particular area was not significant.

Average Number of Palpable Nodes Per Individual

Regional Location of Node	Filariasis	Malaria	Controls
Inguinal	2.4	2.3	1.9
Femoral	1.7	1.4	1.3
Axillary	1.1	0.8	0.8
Epitrochlear	0.4	0.3	0.2

4. The size of the lymph nodes was not characteristic of filariasis, 31 per cent of the cases of filariasis and 29 per cent of the cases of malaria having nodes 1 cm. in length or more. It was observed that the patients in groups (a) and (b) had larger nodes than the patients in the control group. Further investigation revealed that there was a very definite correlation between the presence of large lymph nodes and the existence of active fungous infection in both of the overseas groups.

5. Special attention was given to the examination of spermatic cords. It was found that 14 per cent of the patients with filariasis had thickened cords, as compared to 9 per cent of patients in groups (b) and (c).

In summary, careful physical examination with particular reference to the presence of palpable lymph nodes in 200 cases of filariasis, 271 cases of malaria and 98 men who had not been in tropical areas revealed no significant difference between the patients with filariasis and those with malaria. There was a difference, however, between the overseas groups and the control group, and this difference could be accounted for by the existence of active fungous infection. It was therefore concluded that lymphadenopathy, as observed in this study, could not be used as a diagnostic criterion for filariasis. (Marine Barracks, Klamath Falls - L. T. Coggeshall)

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Headache in Malaria: In a group of 25 selected patients with malarial headache, nicotinic acid given orally in 100 mg. doses was found to relieve the headache in ten cases, to cause moderate improvement in seven, and to be of no benefit in eight.

In view of the pharmacologic safety of this drug and the absence of any other effective therapy, it is felt that nicotinic acid should be given therapeutic trial. (The nature of "malarial headache" has not been established. - Ed.) (J.A.M.A., Nov. 17, '45 - Zeligs)

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Human Food Poisoning by Clostridium Perfringens (Welch Bacillus): Recently McClung has gathered evidence in several outbreaks of food poisoning which points to Cl. perfringens as the etiological factor. Symptoms of the illness included nausea, vomiting (rare), intestinal cramps, and invariably a pronounced diarrhea. Although experimental evidence is thus far lacking, the immediate agent is thought to be an enterotoxin.

In all instances the incriminated food was chicken or chicken broth in which large numbers of these organisms were demonstrated by culture and smear. Gas bubbles were found in the broth at times. In all cases there was a history of the fowl having been cooked on one day and served on the next. It is assumed that the contaminating organisms were present on the fowl following dressing and that they survived the cooking process because of protection by fat.

Control measures which proved successful were improvement of general cleanliness in the kitchens involved and adequate heating of the chicken and broth on the day of serving.

These studies show the importance of using anaerobic culture methods as well as aerobic in the investigation of food-poisoning outbreaks. It should be emphasized, however, that in view of the ubiquitous distribution of this organism, mere demonstration of the organism in a food may not necessarily mean that the food was contaminated sufficiently for this species to be the offending agent.

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Penicillin Treatment of Scarlet Fever: Laboratory and clinical studies have shown that penicillin is highly effective against the hemolytic streptococcus.

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It is more active than sulfonamides in protecting mice against lethal infections with this organism. There are also a number of reports of infections due to hemolytic streptococci which resisted sulfonamide therapy but which responded well to penicillin. Such observations, and the lack of toxicity of penicillin have made it the treatment of choice in severe infections due to hemolytic streptococci.

Results of bacteriological studies on four small groups of cases of scarlet fever are reported by Meade and co-workers. These groups were treated as follows: (1) without sulfonamides or antibiotics, (2) with penicillin intramuscularly, (3) by spraying the nose and throat with penicillin solution, (4) with sulfadiazine orally. The patients' ages ranged from 4 to 15 years. There were only 9 patients in each group, but the differences observed were sufficiently striking to warrant a report.

Nasal and pharyngeal cultures in the control group showed hemolytic streptococci to be persistently present throughout the disease. In only 4 of 9 cases were cultures repeatedly negative before discharge.

It was found that in patients treated with penicillin intramuscularly, in doses of from 10,000 to 15,000 units every 3 hours, hemolytic streptococci disappeared from the nasal and pharyngeal cultures within forty-eight hours, and when the treatment was continued for seven days the original types of streptococci did not appear.

Penicillin solution given to patients by spraying the nose and throat four or six times a day had very little effect on the hemolytic streptococci in the pharynx, but seemed to keep the nose free from these organisms while the treatment was continued.

Sulfadiazine given orally in full doses for seven days resulted in a reduction in the numbers of hemolytic streptococci in cultures obtained during the period of treatment only. In this respect, the results were comparable to those obtained by others in cases of pharyngitis and tonsilitis due to hemolytic streptococci.

The clinical and bacteriological results suggest that early systemic treatment with penicillin in adequate doses and continued for seven days may eliminate the hemolytic streptococcus carrier state and prevent complications due to this organism. The rash and toxic manifestations of scarlet fever are not influenced by penicillin.

It should be emphasized that these conclusions are based on a very small number of cases. They require corroboration and elaboration in a large number of cases of various kinds of streptococcus infections. (J.A.M.A., Nov. 17, '45)

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Trachoma: During a 24-month period Thygeson has observed 19 cases of active trachoma in the eye clinic of an army hospital in this country. In addition, 13 cases of healed cicatricial trachoma were discovered by him in the course of a routine eye survey in the same institution. Of the active cases, two were in foreign-born men from areas in which trachoma is rampant. The remaining 17 were from scattered parts of the U.S., only 4 being from the so-called "trachoma belt". Nine of the cases were believed to be infected before induction into the Service. In but one instance was there evidence that the condition had been recognized on induction or pre-induction physical examinations. In view of this report and of the possible exposure of occupation troops in areas where trachoma is endemic, this disease would appear to be of greater military importance than has generally been realized.

The criteria for diagnosis which were applied in these cases were (1) the presence of a follicular or papillary hypertrophy localized predominantly in the upper tarsal conjunctiva, and (2) the presence of a microscopic or gross pannus involving the upper limbus region predominantly, with associated punctate fluorescein-staining epithelial lesions and subepithelial filtrates. Early slit-lamp changes in the upper limbus make diagnosis possible at an early stage. When careful slit-lamp studies are made the number of doubtful cases is reduced to a minimum.

While the cases reported could be diagnosed on the basis of clinical findings alone, a high percentage of cases of trachoma may be diagnosed on the basis of laboratory findings also. The essential findings are: (1) the typical cytoplasmic inclusion bodies which are common to trachoma and inclusion conjunctivitis, and (2) certain cytologic changes which serve to differentiate these two diseases.

(a) In follicular material in trachoma, there is present degeneration of nucleus and cytoplasm of large mononuclear cells making up the germinal centers of the follicles. These changes are absent in similar material from inclusion conjunctivitis.
(b) In trachoma, many macrophages containing phagocytosed cellular debris are present and few, if any, in inclusion conjunctivitis.
(c) In the conjunctival exudate in trachoma there are scattered plasma cells. These are not diagnostic, but are suggestive, since plasma cells are rarely seen in exudates from other types of conjunctivitis.

Sulfadiazine and sulfanilamide administered orally were equally effective in treatment. Uncomplicated cases may be treated without resorting to local measures of any sort, although secondary factors must be evaluated in therapy, such as secondary bacterial infections, trichiases or entropion and tear deficiency. The effect of sulfonamides was dramatic in the early acute cases and

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slower in the older or more mild cases. Seventeen of eighteen cases became free of symptoms and clinically healed under sulfonamide therapy. The one case not completely healed was complicated by vernal catarrh. One case was healed by penicillin therapy, but a second case which failed to respond to penicillin cleared up when sulfonamides were administered. Dosage was adjusted in order to maintain a blood level of from 3 to 5 mgms. per cent for at least two weeks (ordinarily accomplished by dosage of 3.0 or 4.0 mgms. daily), or until the cornea was free of subepithelial infiltrates and punctate epithelial erosions. Previous studies have shown that recurrences almost never occur once the cornea is completely healed. (Mil. Surg., Nov. '45)

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Nontuberculous Pneumonia Complicating Pulmonary Tuberculosis: As a result of a study at a large general hospital, Hogan has reported that the incidence of pneumonia complicating pulmonary tuberculosis is significantly low. In the cases observed, the course of the pneumonia and the outcome were altered by the presence of tuberculosis. In a series of 111 cases, 60 per cent ran an atypical course - 72 per cent of the active cases and 54 per cent of the inactive ones. The mortality was 38 per cent, but the deaths were almost twice as numerous when the tuberculosis was active (56 per cent) as when it was inactive (30 per cent). Reactivation of a tuberculosis may be expected in 15 per cent of the patients who develop superimposed pneumonia, whether or not the same lobe is involved and whether or not it is specifically treated. No definite therapeutic implications are apparent. The question of bacterial antagonism appears to be a fertile field for future investigation. (N. Eng. J. Med. - Nov. 8, '45)

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Burns from Fluoroscopy: Since publication of an item in the Bumed News Letter (Vol. 6, No. 10, p. 9) on injury to patients as a result of injudicious handling of fluoroscopic units, information has been received concerning a number of cases of injury from overexposure of personnel operating such units. Attention of all X-ray personnel is again invited to the potential hazards of fluoroscopy both to operator and patient.

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The Penetration of Penicillin into Joint Fluid: Penicillin administered intramuscularly in 7 cases of hydrathrosis (rheumatoid arthritis), in doses of

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25,000 and 40,000 units at 3-hour intervals, was found to penetrate rapidly into joint fluid and to attain levels comparable to those attained in blood serum. Penicillin in maximal antibacterial quantities was found to persist longer in the joint fluid than in the blood serum. Penicillin did not tend to accumulate in joint fluid. (Am. J. M. Sc., Nov. '45)

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The Phantom-Limb Syndrome: After amputation of a major extremity a large proportion of patients will retain specific impressions of the missing limb. Such phantom-limb symptoms become clinically important when associated with protracted or severe pain. However, of all patients with well-defined phantom-limb sensation, comparatively few (probably less than 10 per cent) will have severe, persisting pain referred to the phantom limb.

Attempts to determine the role that the neuroma plays in such cases is frequently difficult, since any disturbance of the stump is likely to aggravate pain in the phantom limb. This aggravation may occur when the neuroma is disturbed, but it may also be set off by bumping the stump, pinching the skin, tapping the bone-end, rubbing the scar, etc. However, in patients having definite and characteristic phantom-limb symptoms without severe pain, the neuroma may be more readily studied, and its relation to the phantom-limb impression and to phantom pain may be more accurately examined. This study is based on such cases.

Forty-two patients with a total of 50 amputations of a major extremity were studied in detail. The group is representative of amputations in civilian life. Of the fifty amputations only 1 was never associated with phantom-limb symptoms.

The phantom limb is not a simple, total reproduction of the amputated extremity. In amputations of the upper extremity the fingers are most prominently reproduced. The palm is less frequently felt, and the wrist and dorsum of the hand are usually not present. The forearm and upper arm are rarely perceived. Many patients give the impression that they feel "the whole thing", but on careful questioning it is evident that the posture and presence of much of the phantom limb are inferred, often from small portions of the hand or fingers, of which the patient has very specific impressions. In amputations of a lower extremity, similar phantom patterning is found. In neither extremity does the pattern correspond to the major peripheral-nerve distributions.

A majority of these patients felt that their phantom limbs had been clearly established immediately or soon after amputation. The neuroma is not established early enough to be the determining factor in these initial symptoms.

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In 14 of these patients with twenty amputated limbs, a total of thirty major nerve neuromas were accessible. On vigorous palpation of the neuroma, most of the patients described their sensation as like "striking your funny bone". In no case did stimulation of the neuroma excite or simulate typical phantom sensations.

Livingston believes that the high incidence of phantom-limb impression after amputation, its early appearance and its stability suggest a central, rather than a peripheral denominator for these symptoms. The occurrence and persistence of severe phantom-limb pain in a comparatively small proportion of the patients with phantom-limb symptoms suggest an irritative disturbance that is superimposed on the underlying phantom-limb mechanism. Evidence from these observations and from clinical experience suggests that neuroma of the major peripheral nerve is rarely the "key" factor in this irritative process. (J. Neurosurg., May '45 - Livingston)

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Some Effects of Centrifugal Force on the Cardiovascular System in Man: By means of the man-carrying centrifuge, the effects of increased positive G on the cardiovascular system were studied in seventy-two subjects during 690 tests at from two to ten G. Kodachrome motion pictures showed, as increased G was applied, blanching of the face and distention of the superficial leg veins which persisted until a few seconds after the G began to diminish. The leg veins then reverted to normal, but the facial blanching was followed by flushing which lasted from 10 to 20 seconds.

The ear opacity (a qualitative measure of the blood content of the ear) began to decrease with the onset of increased G, reaching a minimum in from 4 to 6 seconds after G became constant. In from 0.5 to 3 seconds after the G began to decrease, the ear opacity rapidly increased. The increase continued above the initial level, coincident with the facial flushing. The decrease in ear opacity was directly but not quantitatively related to the amount of G applied.

The heart rate increased rapidly with the onset of increased G, attaining a maximum of from 120 to 190 beats/min., depending upon the amount of G and its duration. When the maximum G was maintained for more than from 10 to 20 seconds, the maximum heart rate was relatively constant until the G was reduced. With the reduction of G in short runs, there was a delay of from 2 to 5 seconds before the heart rate suddenly fell to below its initial resting level. This bradycardia coincided with the flushing and increased ear opacity, and was frequently followed by a secondary rise in rate.

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Electrocardiograms from chest electrodes over base and apex of the heart showed the following changes during increased G: The PR interval was shortened. The over-all amplitude of the QRS complex decreased, usually with the main deflexion downward. The T wave flattened and sometimes disappeared. As the G was reduced, the PR interval and QRS complex reverted to their original forms, but the T wave became greatly increased in amplitude and sometimes biphasic for from 2 to 5 minutes. During this period, sinus arrhythmia and, more rarely, ventricular extrasystoles appeared.

Anteroposterior X-ray films of the chest (1 second exposure) taken during increased G showed a marked reduction in cardiac shadow as compared to that of control films.

The circulatory changes described in this paper could not be related to the level of G at which a subject would experience loss of vision or consciousness. However, the pooling of the blood in the lower extremities, reduction in cardiac shadow, facial blanching, decrease in ear opacity and associated changes in heart rate appear to be dependent variables and throw some light on the action of increased positive G on man. (J. Physiol., June '45 - Franks et al)

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Protein Metabolism in Inflammation: Adult dogs were given a protein-free diet, plus casein, which contained 80 calories per kilo and 0.4 Gm. nitrogen per kilo per day. Sterile, controlled inflammation was produced by subcutaneous injection of turpentine. This reaction was characterized by local swelling, induration, and abscess formation and was terminated by rupture or incision after from 3 to 5 days. General reactions included malaise, fever, leucocytosis and increased urinary nitrogen. For from 3 to 6 days after injection of turpentine, the nitrogen intake was provided by amino acids given parenterally (a solution of the ten essential amino acids (Rose) plus gluvine).

A normal dog with a normal protein intake showed a negative nitrogen balance after turpentine injection; the urinary nitrogen doubled as in inflammation during fasting. A protein-depleted dog (low protein reserves produced by very low protein intake) given a normal protein intake after injection of turpentine maintained nitrogen balance; urinary nitrogen rose only slightly. With a high (doubled) protein intake the depleted dog showed a strongly positive balance.

Normal dogs with high (doubled) protein intake reacted to injection of turpentine with doubled urinary nitrogen output on individual days, and therefore were maintained in approximate nitrogen balance and weight balance. This

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end may be achieved equally well or better by oral feeding, when such is possible and when absorption is unimpaired.

The increased nitrogen excretion after injury is directly related to the state of the protein reserves of the body. Increased catabolism, not inhibition of anabolism, best explains the excess urinary nitrogen. Protection during injury of valuable protein reserves appears possible through an adequate intake of protein nitrogen. (J. Exper. Med., July '45 - Madden and Clay)

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An Experiment in the Psychiatric Treatment of Promiscuous Girls: A demonstration of the application of psychotherapy and psychiatric case work as a preventive measure in venereal disease control was undertaken by the Psychiatric Service of the San Francisco City Clinic in cooperation with the United States Public Health Service, the California State Department of Public Health and the City and County of San Francisco Department of Public Health to provide for research and treatment of promiscuous girls in connection with a venereal disease clinic.

The chief objectives of the Service were to determine the personality and environmental factors that motivated the promiscuous behavior of girls referred, and to determine to what extent psychiatric treatment might be effective in helping them to make satisfactory adjustments, thus removing the likelihood of their behavior leading to the dissemination of venereal disease.

An analysis was made of 365 females, of whom 287 were classified as promiscuous and 78 as potentially so.

An extensive descriptive and historical work-up, including both social and personal factors, was made for each patient, to determine whether some distinguishing characteristics might be found for promiscuous women. No single factor was found which, in itself, would either denote promiscuity or exclude it, but rather a nonspecific etiology was found. Unsatisfactory familial relationships were among the basic factors which, although not predetermining promiscuity, occurred frequently enough to suggest a direct relationship to promiscuous behavior. Sex instruction which the patient had received was usually described as being inadequate and unscientific. Conflicts of various types with reference to sex were seen in a majority of the patients. Uneven development in physical, emotional and social maturity within the individual patients was usually noted. The occurrence of neurotic tendencies was frequent, and there were suggestions that promiscuity might be considered as a neurotic equivalent

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in some cases. Environmental factors such as unsatisfactory living conditions, the absence of community ties, and the making of casual friendships were found often to have contributed to the promiscuous behavior.

Among those who were habitually promiscuous, one-half fell into the Conflictual group, whose promiscuity was the result of intrapsychic conflicts which were often in the sexual area. Nearly one-fifth were in the Dependent group, whose sexual behavior was just one example of the activities which are characteristic of the unstable patient who lacks social responsibility and self-restraint. A small percentage fell into the Non-conflictual group, whose promiscuity seemed to present no conflicts within the patient or between her and her social group.

Changes observed in patients during the course of treatment suggested that they had benefited from the services given and in particular had reduced their promiscuity, although only 40 per cent of the patients given service could be followed up successfully after six months.

It was concluded that psychiatric facilities can be used advantageously in connection with a venereal disease clinic to decrease, modify or eliminate promiscuity and resultant venereal disease among a suitable group of female patients who have been selected carefully and who voluntarily make use of treatment service. In addition, it was recommended that psychiatric treatment should be made available to promiscuous male patients who are in need of counselling. (Venereal Disease Div., USPHS)

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Pregnancy Tests: A recent paper by Engelfried and co-workers of the Department of Biological Chemistry, Naval Medical School, Bethesda, discusses the relative merits of commonly-used laboratory tests for pregnancy. As a result of their studies these workers recommend the use of the Aschheim-Zondek test, using mice, in preference to the Friedmann test, using rabbits, or to the recently-introduced frog test. The following factors were considered in the study: accuracy of result, time required for completion of tests, cost of purchase and maintenance of animals, laboratory time required to perform the test, experience and training required of technicians for satisfactory performance of tests.

The technic of the Aschheim-Zondek test as used at the Naval Medical School follows:

The first voided morning urine specimen, having a specific gravity of at least 1.015, or serum is used.

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All urine specimens received by mail are detoxified by shaking 1 part of urine with approximately 3 parts of ether before injection into the test animals. Four immature, female mice from 3 to 6 weeks of age are used for the test. The majority of the mice used were obtained from four commercial breeders.

Each mouse is injected subcutaneously in the loose skin in the back, once daily for three successive days, with 0.25 ml. of urine or serum. On the morning of the fifth day (approximately 90-96 hours after the initial injection), the mice are asphyxiated with illuminating gas, after which they are secured with pins to large animal boards and are opened. The number of corpora hemorrhagica and corpora lutea are counted on each ovary of all mice. The test is reported positive if one or more hemorrhagic follicles, or a definite corpus luteum is present on any one of the animals in the set. If the presence of a follicle is questionable, the test is reported as doubtful and another specimen is requested. In the absence of both corpora hemorrhagica and corpora lutea, the test is reported as negative.

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Effect of Benzyl Benzoate on Human Skin: Tests on 84 volunteers indicate that undiluted benzyl benzoate is not a primary irritant or a sensitizing agent on human skin. Cloth impregnated with this mite repellent did not cause primary irritation on human skin or elicit skin reactions in subjects who 3 weeks previously had had repeated skin exposure to the undiluted drug. (OEMcmr-103, Sulzberger et al, Cornell Univ. - CMR Bulletin #61)

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Reports on Research Projects at the Naval Medical Research Institute, Bethesda, Maryland, Available to Medical Officers:

X-278 Further Studies of Susceptibility to Seasickness by a Motion-Sickness Questionnaire, Report No. 6.

A questionnaire for use in predicting susceptibility to seasickness was given to several groups of naval personnel to determine its potential usefulness. The questionnaire is believed to have sufficient validity and reliability to be of value in screening out persons who would be severely affected by seasickness.

X-465 A Study of the Diet of Orthopedic Patients in a Ward at a U. S. Naval Hospital.

Factors considered are amount and adequacy of intake, wastage, and education of patients as to the importance of food in convalescence.

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X-539 The Distribution of Exoerythrocytic Parasites and the Tissue Reaction Caused by Blood-induced Pl. Gallinaceum Infection in Chicks.

The disease induced by Pl. gallinaceum in chicks is discussed.

Reports on Research Projects at the Medical Field Research Laboratory Camp Lejeune, N. C., Available to Medical Officers:

X-526 Validation of Physical Fitness Tests by Evaluation of Performance of Subjects.

Results indicate that the step-up test, body sway test and medical officer's average rating were the only indices significantly related to subsequent performance on the fatigue test.

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Course in Medical Statistics: The Bureau of Medicine and Surgery is arranging for the training of Medical Officers in the speciality of Medical Statistics at the School of Hygiene and Public Health of Johns Hopkins University. Medical Officers wishing to take this course should submit an application to the Chief of the Bureau of Medicine and Surgery. (Medical Statistics Div., BuMed - F. R. Lang)

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Pathological Specimens from Tropical Diseases: The Medical Museum of the Naval Medical School is in need of specimens showing the pathology of various tropical diseases. Medical officers stationed in tropical areas are urged to ship representative specimens to the Medical Officer in Command, Naval Medical School, National Naval Medical Center, Bethesda, Maryland. These specimens will be mounted and used for museum purposes. Information on proper preservation and packing of pathological material may be found in BuMed Letter, A11-P3-4(041), dated April 15, 1943, reprinted in the BuMed News Letter of April 30, 1943.

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The Postwar Status of H(S) Officers in the Navy: The Bureau of Medicine and Surgery is vitally interested in retaining those H(S) officers who, by reason of their specialized knowledge, ability and experience, are absolutely indispensable to the proper functioning of the Medical Department.

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Pending the enactment of legislation for the commissioning of scientists in the regular U. S. Naval Service, the Bureau has recommended the continuation of the H(S) officer designation through the fiscal year 1947 in order to retain such officers on an active duty status through this period. It is hoped that we will be able to announce definite action on this legislation in the near future.

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Specialist Training Program for Medical Officers: Establishment of a long-term program for training of specialists, involving the designation of nine large naval hospitals as special centers of instruction, has been announced by the Surgeon General.

Intended to fulfill more adequately the medical and surgical needs of an expanded peacetime Navy, the program will make available to medical officers a complete term of specialization training comparable to the best obtainable in civil life. All of the recognized specialities will be taught including anesthesiology, dermatology and syphilology, internal medicine, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, plastic surgery, psychiatry and neurology, radiology, surgery and urology.

The nine postgraduate teaching centers will be set up at the following naval hospitals: Chelsea, Mass.; St. Albans, N.Y.; Philadelphia, Pa.; Bethesda, Md.; Great Lakes, Ill.; San Diego, Long Beach and Oakland, Calif.; Seattle, Wash.

The board of honorary consultants to the Medical Department of the Navy, composed of ranking civilian members of the profession, have actively cooperated in formulation of plans and will assist in their development. The consultants are: Dr. Donald C. Balfour, Director of the Mayo Foundation and Clinic, Rochester, Minn.; Dr. Richard B. Cattell, Chief of the Surgical Section, Lahey Clinic, Boston, Mass.; Dr. Edwin J. Cohn, Department of Physical Chemistry, Harvard Medical School, Boston, Mass.; Dr. Frank P. Corrigan, American Ambassador to Venezuela; Dr. Walter E. Dandy, Professor of Neurosurgery, Johns Hopkins University Hospital, Baltimore, Md.; Dr. Frank H. Lahey, Director of the Lahey Clinic, Boston, Mass.; Dr. Oswald S. Lowsley, Director of the Department of Urology, James Buchanan Brady Foundation, New York, N. Y.; Dr. James E. Paullin, Professor of Clinical Medicine, Emory University, Atlanta, Ga.; Dr. W. Calhoun Stirling, Urologist, Washington, D. C.; Dr. Edward A. Strecker, Professor of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.; and Dr. Meyer Wiener, Professor of Ophthalmology, Washington University, St. Louis, Mo.

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Instructors will include not only the regular staffs of the nine special training centers but also members of the Naval Reserve Medical Corps who are outstanding in various fields of medicine and surgery. Duties of the latter, as volunteers, will include consultations in problem cases and organization of the curricula. Headquarters of the program will be in the Bureau of Medicine and Surgery and a central advisory committee will be formed.

Present plans, which are flexible, call for a definite period of training for the young doctor who enters the Navy upon his graduation from medical school. This period would cover one year's internship, one or more years of residency training, two years of sea or foreign shore duty and, finally, a definite period of intensive work in this country in that field of medicine which the officer has chosen and which has been approved by the central advisory group.

Chief advantage of the program, from the individual doctor's point of view, is that it gives him an opportunity to become a specialist without the financial, assignment and other complications which attend the same effort in civil life. The training will not be given to those medical officers who do not wish to specialize or who demonstrate that they are better fitted for general practice.

Internships and residency training will continue to be given at all naval hospitals which are properly accredited, with the more advanced teaching being offered at the nine specialization centers. Augmenting the latter will be the postgraduate facilities of a number of civilian teaching institutions, to be announced later.

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Transfer of Medical Officers to USN: Legislation is pending in Congress which will govern the transfer of Reserves to the regular Navy and which is expected to be enacted into law within a very short time. A board is now in session in the Navy Department reviewing the applications of medical officers for transfer to the regular Navy.

The following information abstracted from BuPers Circular Letter, dated 1 October 1945 is believed to be of interest to medical officers.

1. Rank and promotion.

Any officer who transfers will be placed on the over-all list with the same rank and precedence he now holds. He will retain his temporary rank and will be eligible for further temporary promotion. When redistribution of rank is made upon the termination of temporary promotions, he will receive the

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same consideration for new rank as other regular Navy officers. He will become eligible for promotion at the same time and in the same manner as all U. S. Navy officers.

2. Assignments of lineal position to transferred officers.

Lineal position as referred to herein, means the position in order of seniority within the regular Navy which an officer occupies by virtue of his rank and date of rank, excluding spot appointments. In the case of regular or Reserve officers with the same dates of initial commission, a board will be established to determine their relative precedence among themselves. Reserve officers who have continuously held commissioned rank in the Reserve from a date prior to 8 September 1939, and who may transfer under the proposed legislation will be assigned lineal position corresponding to the precedence, relative to regular officers, to which he is entitled by existing law. That is, in the assignment of precedence, each officer in this category will receive one-half (1/2) credit for the length of time which he served, prior to 8 September 1939, in the rank which he held on 8 September 1939. Reserve officers transferred to a permanent rank will be assigned the position on the lineal list of the appropriate regular line or staff corps that they would occupy thereon according to their advancements in commissioned rank as Reserve officers (exclusive of spot appointments) and according to the rate of such advancements, just as if they had, in fact, been commissioned in the regular service on the date they reported for active duty in the Naval Reserve and in the rank they held at that time.

3. Assignment of initial rank and grade.

A newly appointed officer will first receive an initial permanent rank or grade in the regular Navy in the same permanent rank or grade held by those officers already in the regular Navy who are contemporaries of such officer. In addition, he will be given a temporary commission in the regular Navy in his rank or grade at the time of appointment, or if he is a former officer, in the rank or grade held by him at the time of his resignation. Furthermore, he will be eligible for temporary promotion as long as such promotions remain in effect. The temporary rank achieved by such an officer will continue until such time as the temporary appointments of all officers are terminated. At that time, a redistribution in permanent ranks will take place and the permanent rank initially assigned to such an officer may be changed as effected by such redistribution. All officers of the regular service, whether newly appointed or presently appointed, will receive the same treatment in subsequent rank redistribution. The rank accruing to an individual as a result of this redistribution will depend first, on the needs of the service at that time for officers in the various ranks, and second, on the lineal position which the officer holds.

(Not Restricted)

4. Age requirements.

It is anticipated that the age requirements for transfer will be modified as follows for the Medical Corps:

Applicant must not have attained the age shown on 1 January 1945, for the rank specified.

	Date Rank	Age
Lt. Comdr.	9- 8-39 to 2-29-44	40
Lt. Comdr.	3- 1-44 to 3-14-44	39
Lt. Comdr.	3-15-44 to 10-16-44	38
Lt. Comdr.	10-17-44 to 7-19-45	37
Lt. Comdr.	7-20-45 to 10- 1-45	36
Lieut.	9- 8-39 to 6-30-44	36
Lieut.	7- 1-44 to 10- 1-45	35
Lt. (jg)	9- 8-39 to 8-31-44	35
Lt. (jg)	9- 1-44 to 10- 1-45	34

There are no age requirements for officers of the rank above Lieutenant Commander.

Reserve medical officers who are released from active duty and desire to submit application for transfer to the regular Navy within the six (6) months' period allowed, will communicate with the Commandant of their respective Naval Districts, who is in a position to assist them in the preparation of their applications. In conclusion, the Bureau invites attention to the press release of Vice Admiral Denfeld, concerning Reserve officers transferring to the regular Navy - "We intend to have one Navy. Our determination is to assure those Reserve and temporary USN officers who transfer to the regular Navy absolute equality of treatment in assignments, promotions, and in the development of their careers."

Attention is especially invited to the article contained in the Bumed News Letter dated 12 October 1945, Volume 6, Number 8. This article outlines the advantages and benefits received by officers of the regular Navy. Attention is also invited to ALNAV #283 contained in this Bumed News Letter, whereby Reserve Officers who transfer to the regular Navy and later feel that they are unsuited for a Naval career, may submit their resignations at any time at the pleasure of the President, but in any event, such officers may resign on 1 January 1947, and their resignation will automatically be accepted by the President. Detailed information on transfer of Reserve and temporary USN officers to the Regular Navy is contained in Circular Letter No. 288-45, dated 15 November and printed on page 46 of the Navy Department Semimonthly Bulletin of 15 November 1945.

(Not Restricted)

The Bureau of Medicine and Surgery will be pleased to answer any specific questions relative to transfer to the Medical Corps of the regular Navy. (Pers. Div., BuMed - W. W. Hargrave)

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(Not Restricted)

Public Health Foreign Reports:

Disease	Place	Date	Number of Cases
Plague	Belgian Congo, Kateri	Oct. 20-27, '45	7 suspected, fatal
	Great Britain, Malta	Oct. 20-27, '45	6 (1 fatal)
	Italy, Taranto	Oct. 13-27, '45	2 (1 fatal)
	Morocco (French)	Oct. 1-10, '45	24
	Palestine, Haifa	Oct. 13-20, '45	2
	Peru, Piuro Dept.	September '45	1 (1 fatal)
	Tunisia	Sept. 21-30, '45	1
Smallpox	British E. Africa, Tanganyika	Sept. 15-22, '45	292 (40 fatal)
	Morocco (French)	Oct. 11-20, '45	115
	Rhodesia, Northern	Sept. 15-22, '45	308 (2 fatal)
Typhus Fever	Chile	Aug. 2-Sept. 8, '45	41 (5 fatal)
	Colombia, Bogota	Oct. 18, '45	7 present, fatal
	Egypt	Sept. 22-29, '45	18
		Oct. 13-20, '45	3
	Morocco (French)	Oct. 1-20, '45	268
Yellow Fever	Venezuela	Oct. 24, '45	1 confirmed

(Pub. Health Foreign Reps., Nov. 16 and 23, '45)

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(Not Restricted)

The following item on procedures for requisitioning medical stores in the Pacific Ocean Area is presented at the request of the Commander, Western Sea Frontier and of the Chief, Materiel Division, BuMed.

Subj: Information Regarding Requisition Control Unit, Commander Western Sea Frontier, and Procedures Applicable in Requestioning Medical Stores in Pacific Ocean Area. 24 November 1945

Refs: (a) CNO Dispatch 231233 June to ComWestSeaFron.
(b) ComServPac Dispatch 012358 of Sept. 1945.
(c) CinCPac/POA HedPEARL Dispatch 212354 of Oct. 1945.
(d) ComServPac Ltr. Serial 46-THB/Jy, A2-11/FF 12-12(6), L8-2 Serial 4111, dated 1 Aug. 1945.

1. Reference (a) approved the establishment of the Requisition Control Unit within Command of Western Sea Frontier. The establishment of the Requisition Control Unit directly affects the Medical Supply System.

2. In order to acquaint Medical Officers with present functions of the Requisition Control Unit and in order to review procedures applicable in requesting Medical Stores in Pacific Ocean Area, the following summary is given.

3. Requisitions for Medical and Surgical Supplies and Equipment prepared by shore based activities are to be forwarded to a specific Medical Supply Depot or Storehouse in the Central or Western Pacific. The specific Supply point depends upon the geographical location of the shore activity preparing the requisitions. Reference (c) tabulates supply points and dependent shore activities. These major supply points submit replenishment requisitions to the Requisition Control Unit via ComServPac channels, as outlined in reference (b).

4. Ships will procure their Medical and Surgical Supplies from the nearest supply facility ashore or afloat. These sources are usually indicated in bulletins prepared by the Service Force activity in each port. Reference (c) states that requisitions from ships will be submitted to continental agencies only when the vessel is operating in continental waters. The Requisition Control Unit does not at present assume cognizance over requisitions submitted by vessels in West Coast ports. Therefore, upon departure of the ship from continental waters, reference (c) indicates that it is desirable in most cases (for ships - ED) to cancel outstanding items on requisitions submitted direct to continental supplying activities and initiate new procurement from appropriate Medical Supply Storehouses or Medical Supply Depots in forward areas. This would also be a good policy to carry out as ships move from one location to another in the overseas area.

5. Requisitions submitted by ships and bases overseas for items not available in

(Not Restricted)

overseas Medical Supply Depots or Storehouses will be processed for overseas shipment by the Requisition Control Unit if appropriate notation to that effect is made on the reverse side of the requisition or if validated by ComServPac. Requisitions forwarded by ships overseas direct to continental activities are passed to the Requisition Control Unit for review. Much unnecessary delay can be obviated by careful compliance with the foregoing. The original and four copies of a requisition are necessary.

6. Emergency requirements should be handled by dispatch in accordance with CinCPac letter CL37-45. Such dispatches as are addressed direct to US Naval Medical Supply Depot, Oakland or Brooklyn should also be addressed to ComWesSeaFron for information. The Medical Supply Depot having action will notify the Requisition Control Unit of the date and manner of shipment. All inquiries regarding these requisitions should be addressed to Requisition Control Unit.

7. Reference (d) outlines procedure for numbering all requisitions including Medical and Surgical requisitions. This procedure shall be used by ships and bases in Pacific Ocean Areas with exception of areas under cognizance of 14ND and NorPac. In cases where reference (d) has not been complied with and requisitions are received by the Requisition Control Unit incorrectly numbered, a number will be assigned by the Requisition Control Unit. The requisitioning activity shall be notified of the number assigned which will be considered as the original number. This number shall be used throughout all stages of material supply.

8. Processing of requisitions received within the Requisition Control Unit is carried out as follows:

(a) The Requisition is recorded and the letters WM are added to the requisition number. The letter "W" denoted requisition was processed by Requisition Control Unit. The letter "M" is added to denote "Medical and Surgical Material".

(b) The requisitioning activity is notified that the requisition has been processed through Requisition Control Unit and is advised the number assigned in case change is made.

(c) Copy of the requisition is then jacketed and set up in tickler file in order that future progress of the requisitioned items may be closely followed.

(d) The requisition is then passed to the appropriate continental supply activity for technical monitoring and shipment or procurement of the material involved.

(e) The continental supply activity is requested to keep the Requisition Control Unit informed of all changes in status of the requisition and to supply copies of all transfer requisitions and Bills of Lading. This

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information is filed in requisition jacket in order that all information regarding the requisition is available at all times.

(f) Within a specified period if Requisition Control Unit has not received notification that all items of the requisition have been shipped, follow-up action is initiated to insure that the material requested is enroute or that proper steps have been taken to procure the material. The requestioning activity is notified of any anticipated delay.

(g) Shipment data is furnished the requisitioning activity as items are shipped. Upon cancellation or completion of shipment of all items involved the requisition jacket is cleared and forwarded to Master File Section.

9. By establishing a centralized control point, the communications load between requisitioning activities in the Pacific and continental supply activities is reduced; methods of requisitioning processes are standardized, supply depot work is facilitated, more effective follow-up is provided, the freight deliveries are coordinated with ship movements and available shipping space, both by sea and air.

10. Medical Officers should address all inquiries concerning requisitions processed through Requisition Control Unit to Staff Headquarters Commander Western Sea Frontier; Code 3311D, which is the designation for BuMed Section with the Requisition Control Unit.

11. This office is located in the Federal Building, San Francisco, California, telephone number MArket 3828, extension 6987. Upon request copies of the "Plan for Establishment of the RCU, Western Sea Frontier, 28 May 1945" may be obtained from this address. (Mat. Div., BuMed. - K. C. Melhorn)

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(Not Restricted)
Pers-319-MLB
P18-1
14 November 1945

To: All Ships and Stations.

Subj: Convalescent Leave.

Ref: (a) BuPers ltr. Pers-630-RFT(1), P18-1, of 26 Apr. 1943 (as modified by ref. (d)), re: Establishment of convalescent-leave status for enlisted men hospitalized as the result of illness or injury which necessitated their evacuation from overseas.

(b) ComdtMarCorps ltr. 2445 DFB-322-mp, of 8 June 1943 (as modified by ref. (g)), re: Establishment of convalescent-leave status for Marine Corps enlisted personnel hospitalized as the result of illness or injury which necessitated their evacuation from overseas.

(Not Restricted)

(c) BuPers Circ. Ltr. 196-43, re: Establishment of convalescent-leave status for officers evacuated from overseas because of illness or injury; N. D. Bul. Cum. Ed. 1943, 43-1455, p. 867.

(d) BuPers Circ. Ltr. 296-44, re: Authorization for transfer of overseas casualties to naval hospitals nearer their homes at Government expense; AS&SL July-Dec. 1944, 44-1144, p. 381.

(e) ComdtMarCorps Letter of Instruction 865, of 16 Oct. 1944, re: Authorization for transfer of Marine Corps overseas casualties to naval hospitals nearer their homes at Government expense.

(f) BuPers Circ. Ltr. 28-45 (as modified by BuPers Circ. Ltr. 175-45), re: Abuses in granting leave and outlining of proper procedure and clerical forms to be used; AS&SL Jan.-June 1945, 45-153, p. 438, and 45-724, p. 630.

(g) ComdtMarCorps ltr. 1020-3 DFA-904-rlf, MC458943, of 18 May 1945, re: Reduction to 30 days of length of convalescent leave allowed Marine Corps personnel.

1. There are within the United States certain naval medical units and dispensaries which serve many of the functions of a naval hospital and frequently care for a considerable number of patients. These activities have not the authority to recommend sick leave and they have no authority to grant convalescent leave to casulaties evacuated from overseas. There are other patients who, though they are not casulaties evacuated from ships or stations overseas, would nevertheless benefit by convalescent leave. Included in this group are patients requiring additional convalescence while awaiting further surgical procedures such as plastic, neurosurgical, and orthopedic cases which require stage operations with long intervals between stages and other patients not in need of active hospital treatment but still unfit for return to duty without additional convalescence. The delegation of authority to local commanding officers to grant convalescent leave to such patients would facilitate the emptying of hospital beds now being occupied by patients who require no immediate hospital care and would release these patients to a convalescent-leave status. Furthermore, this procedure will eliminate the paper work which would be required if these patients were to be recommended for sick leave by a board of medical survey in accordance with existing instructions, and by permitting immediate action locally in the individual case will serve to vacate hospital beds which would otherwise be occupied until a report by a board of medical survey could be processed.

2. To provide convalescent leave for patients in the above categories and in order to vacate hospital beds now being occupied by patients who actually do not require active hospitalization at the time, medical officers in command of any type of naval hospital are hereby authorized, and commanding officers of naval and Marine Corps activities in the continental United States having

(Not Restricted)

a dispensary, or a naval unit at a civilian hospital, equipped with beds and facilities to care for major surgical and medical cases, are also hereby authorized, in their discretion, upon the recommendation of the senior medical officer and upon receipt of written request from the patient, to grant convalescent leave up to 30 days to any officer or enlisted man of the Navy or Marine Corps, within the command, provided that:

(a) The individual is on the sick list.
(b) The patient is not awaiting disciplinary action or separation from the service by reason of medical survey or retiring-board proceedings.
(c) The medical officer in charge of the case recommends the convalescent leave as being beneficial to the patient's health.
(d) The medical officer in charge of the case certifies that:
(1) The patient is not fit for duty or for separation from service.
(2) The patient will not need hospital treatment during the convales-
(3) Such leave will not be likely to delay final disposition of the case.

3. The authority granted in paragraph 2 is necessarily broad, therefore care must be taken to avoid the misuse of such convalescent leave. Except in the cases of personnel who have been evacuated from overseas it should not be granted for purposes of morale, and in any case should not be granted as a substitute for rehabilitation, annual, reenlistment, recruit, emergency, or survivor leave. It should not be used merely as a means of affording a patient a vacation, nor should it be granted to a patient who is physically qualified for return to duty, nor to a patient who should be discharged from the service.

4. The provisions of reference (f), which directs attention to proper clerical procedure in granting leave, should be complied with in all respects.

5. Nothing contained herein will in any way limit the authority already granted medical officers in command of naval hospitals and naval special hospitals in the continental United States with regard to granting convalescent leave to casualties evacuated from overseas.

--BuPers. W. M. Fechteler. --MarCorps. A. A. Vandegrift.

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(Not Restricted)

The Naval Medical activities listed below have been disestablished by authority of the SecNav. Disestablishing letters in full may be found in the Navy Department Semimonthly Bulletin of 15 November 1945.

Op21D-psp, Serial 117P21, 1 November 1945

U.S. Naval Base Hospital No. 4,
Wellington, New Zealand.

U.S. Naval Base Hospital No. 6,
Espiritus Santo, New Hebrides.

U.S. Naval Base Hospital No. 22,
Okinawa Jima,
Ryukyu Retto, Japan.

Op21D-psp, Serial 118P21, 1 November 1945

U. S. Fleet Hospital No. 107.

Op21D-psp, Serial 116P21, 1 November 1945

U. S. Fleet Hospital No. 104.
U. S. Fleet Hospital No. 106.
U. S. Fleet Hospital No. 112.
U. S. Fleet Hospital No. 115.

Op24B-rb, Serial 30P24, 1 November 1945

U. S. Naval Medical Supply Storehouse,
New Orleans, Louisiana.

Op24B-pd, Serial 31P24, 1 November 1945

U. S. Naval Hospital,
Pearl Harbor, T. H.

Op24B-pd, Serial 33P24, 1 November 1945

U. S. NAVY V-12 DENTAL UNITS

Naval district		Date of disestablishment
Sixth	Emory University School of Dentistry, Atlanta Southern Dental School, Atlanta 3, Ga.	2 November 1945

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U. S. NAVY V-12 DENTAL UNITS (Cont'd)

Naval district		Date of disestablishment
Ninth	Marquette University School of Dentistry, Marquette University, Milwaukee 3, Wis.	27 October 1945
Ninth	University of Louisville School of Dentistry, University of Louisville, Louisville 8, Kentucky.	3 November 1945

U. S. NAVY V-12 MEDICAL UNITS

First	University of Vermont College of Medicine, University of Vermont, Burlington, Vermont	10 November 1945
Eighth	University of Oklahoma School of Medicine, University of Oklahoma, Oklahoma City 4, Oklahoma.	27 October 1945
Ninth	University of Louisville School of Medicine, University of Louisville, Louisville 8, Kentucky.	3 November 1945

Op24B-pd, Serial 27P24, 1 November 1945

U. S. Naval Training School (Hospital Corps),
U. S. Naval Hospital,
Farragut, Idaho.

Op24C-pd, Serial 62P24, 8 November 1945

U. S. Fleet Hospital No. 111,
Guam, Marianas Islands.

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(Not Restricted)
S34-2-(7)(631)
EN28/A2-11
5 November 1945

To: All Ships and Stations.

Subj: Zinc-Coated and Galvanized Food Containers, Replacement of With Corrosion-Resisting Steel and Corrosion-Resisting Double-Clad Steel.

(Not Restricted)

Ref: (a) BuShips ltr. S34-2(631)(330), EN28/A2-11, of 15 Dec. 1943; N.D. Bul. Cum. Ed. 1943, 43-1708, p. 1142.

1. Reference (a) stated that zinc coatings should not be used on the interior of food cooking and stowage containers because zinc salts are harmful when taken internally.

2. It has come to the attention of the Bureau that notwithstanding the instructions contained in reference (a), many ships are equipped with zinc-coated or galvanized containers for cooking, handling, and storing food. Accordingly, to avoid food contamination it is mandatory that all zinc-coated or galvanized containers for cooking, handling, serving, and storing food or beverages, that are in use aboard or procured for vessels to be retained in the active, reserve, and inactive fleets, be replaced at the earliest practicable date with containers manufactured from corrosion-resisting steel or corrosion resisting double-clad steel, as required by applicable plans and specifications.

3. Where the above containers form parts of title "A" equipment their replacement is to be considered as an approved alteration equivalent to a repair. Where the items involved are title "B," the galvanized or zinc-coated containers should be surveyed and replacement items requisitioned through normal supply channels. On vessels scheduled for the inactive or reserve fleet the above action should be accomplished prior to withdrawal of the vessels from active status. Where such withdrawal has already been effected, action to accomplish the above replacements should be taken by the activity responsible for the vessel in the inactive or reserve status.

--BuShips. R. W. Bruner.

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(Not Restricted)
BuMed:Y:AVR
A-3/EN10(A)
4 October 1945

To: All Ships and Stations.

Subj: Annual Syphilis Report, NavMed-A (Rev. 8-45), Instructions for Use of, and Preparation and Submission of Letter Report on Reactions Following Administration of an Arsenical Compound.

Ref: (a) Par. 2703, MMD.
(b) Par. 3411, MMD.
(c) App. D, MMD, Bureau Circ. Ltr. Y, subject: Form A, Instructions.

Enc: (A) Sample NavMed-A (Rev. 8-45.)

1. References (a), (b), and (c) are hereby canceled and the following substituted for paragraphs 3411 and 2703.

(Not Restricted)

Par 3411. Form A, Annual Syphilis Report. - This report shall be submitted to the Bureau on 31 December of each year by each Navy and Marine Corps activity or unit. Instructions are on the form.

Par 2703. Letter Report of Reaction Following the Administration of an Arsenical Compound. - This letter report shall be prepared in duplicate giving the following information and shall be forwarded to the Bureau in each case in which a reaction follows the administration of an arsenical compound.

(1) Full name, rate, and date of birth.
(2) Approximate time and place of syphilitic infection, or other disease for which the arsenical was administered. If date and place of infection are unknown or questionable, the circumstances of the case shall be stated.
(3) Method of diagnosis; location and date of appearance of initial lesion; all clinical manifestations which tend to substantiate the diagnosis; date or dates of all dark-field examinations and their results; dates of all serologic tests and their results. If the disease treated is a disease other than syphilis, state the particulars of the case.

(4) Previous treatment:
Amounts and dates of each course of arsenical treatment. Give inclusive dates of each course, the number of injections comprising the course, the total amount of each course in grams, and the type of arsenical administered.

(5) Course of treatment during which reaction occurred:
Size and date of each dose of arsenical compound; state arsenical compound administered.

(6) Information regarding dose causing reaction:
(a) Dilution used.
(b) Age of drug.
(c) Size of dose.
(d) Lot number.
(e) Name of preparation as labeled.
(f) Name of manufacturer.
(g) Time elapsing between the injection and the first symptom or sign of reaction.
(h) Clinical manifestations as entered in the Health Record; in every instance the medical history must be stated in detail.
(i) Laboratory findings; in each instance all laboratory reports, especially blood counts, must be stated.
(j) Treatment given for the reaction; sizes of doses of drugs, time administered, and method of administration.

Enclosure (A)

NAVMED-A (REV. 8-45)

ANNUAL SYPHILIS REPORT FOR THE YEAR___

(To Bureau of Medicine and Surgery)

U. S. _____
(Name and address of ship or station)

FORWARDED _____
(Commanding officer)

SUBMITTED _____
(Medical officer)

_____ U. S. N.

_____ (MC), U. S. N.

	NEGROES	ALL OTHERS
A. NUMBER OF PERSONS ON BOARD ON 31 DECEMBER WHO HAVE OR HAVE HAD A HISTORY OF SYPHILIS		

B. ANTISYPHILITIC TREATMENTS

NAME OF PREPARATION	*(Column 1)* NUMBER OF PERSONS ON BOARD 31 DEC. WHO WERE TREATED DURING YEAR			*(Column 2)* NUMBER OF DOSES ADMINISTERED DURING YEAR		
	USN AND USMC PERSONNEL		OTHER PERSONNEL*	USN AND USMC PERSONNEL		OTHER PERSONNEL*
	NEGROES	ALL OTHERS		NEGROES	ALL OTHERS	
PENICILLIN						
ARSENICALS:						
BISMARSEN						
MAPHARSEN						
NEOARSPHENAMINE						
SILVER ARSPHENAMINE						
SULFARSPHENAMINE						
TRYPARSAMIDE						
OTHER ARSENICALS:						

INSTRUCTIONS

ITEM (A): Enter the number of persons on board on 31 December who have or have had a history of syphilis. This is obtained by counting the number of Health Records on board which have a NAVMED–H–7 (Abstract of Antiluetic Treatment) inserted in them.

ITEM (B):

Column 1. Enter the number of persons on board on 31 December who were treated for syphilis with the drugs listed on NAVMED–A by any medical activity during the calendar year. This data is obtained from NAVMED–H–7 (Abstract of Antiluetic Treatment).

Column 2. Enter the number of doses of each drug (number of courses in the case of penicillin) administered in the treatment of syphilis during the calendar year. This data is obtained from NAVMED–H–7 (Abstract of Antiluetic Treatment).

* Under "other personnel" include all persons other than U. S. Navy and U. S. Marine Corps. (Dependents, civilian workers, etc.)

U. S. GOVERNMENT PRINTING OFFICE 16—46182-1

(Not Restricted)

(k) Time of termination of case. State date of recovery, state date of transfer and place to which transferred.

2. An original distribution of 20 subject forms will be made to all activities of the Navy and Marine Corps having a medical-department representative. Additional copies will be stocked at all naval medical supply depots and storehouses and will be listed in the Medical Supply Catalog as follows:

Stock No.	NavMed	Item title	Unit
S16-020	A	Annual Syphilis Report	Sheet

3. Immediately on receipt of the revised forms all stocks on hand of the old Form NavMed-A shall be destroyed.

--BuMed. Ross T McIntire.

LT.CDR.JACK BASMAN MC USNR

BUREAU OF MEDICINE & SURGERY,
NAVY DEPARTMENT,
WASHINGTON, D.C.

BLDG. 3, ROOM 21 X.